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ABSTRACT

This report discusses efforts to ensure and promote quality child care through enforcement of state standards and other activities. The Child Care and Development Block Grant Act of 1990 authorized the dispersing of funds to states for child care services through the United States Department of Health and Human Services (HHS). These funds are used for such regulatory activities as screening applicants for licensure as child care providers, on-site monitoring, and imposing sanctions. Other methods used by states to ensure safety in child care settings include educating parents, training providers, establishing complaint hotlines, and requiring liability insurance. The report details the insufficiency of authorized funds for improving quality in child care, and offers recommendations concerning ways HHS can improve safety in child care settings. Appendixes include a description of the scope and methodology of the study that produced this report, tables and graphs that present data on child care licensing and enforcement activities, comments from HHS, and a list of major contributors to the report. (PM)

United States General Accounting Office

GAO

Report to Congressional Requesters

November 1992

CHILD CARE

States Face Difficulties Enforcing Standards and Promoting Quality

GAO/HRD-93-13

GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-250794

November 20, 1992

The Honorable Edward M. Kennedy
Chairman, Committee on Labor and Human Resources
United States Senate

The Honorable Christopher J. Dodd
Chairman, Subcommittee on Children, Family, Drugs,
and Alcoholism
Committee on Labor and Human Resources
United States Senate

The demand for child care has dramatically increased over the last 20 years. The percentage of mothers in the work force with children under the age of 6 has grown from 30 percent in 1970 to almost 60 percent in 1991, causing much of this demand. Children who are cared for outside their home by those other than relatives are typically in child care centers or family day care homes.[1] A recent study estimates that in 1990, 7.6 million children under the age of 13 were enrolled in child care centers and 4 million were in family day care homes.[2]

This report responds to your requests regarding state efforts to ensure and promote quality child care through enforcement of state standards and other activities. Concerned about the availability and quality of child care services, the Congress passed the Child Care and Development Block Grant Act of 1990 (CCDBG). The Congress appropriated about $732 million for fiscal year 1991 and around $825 million for fiscal year 1992 to implement CCDBG. CCDBG embodies two goals: to help states subsidize child care services for low-income families and to improve the overall quality of child care.

In discussions with your offices, we agreed to (1) examine the activities that states conduct to ensure that providers meet state child care standards, (2) identify problems states may have in conducting these activities, and (3) explore how CCDBG may affect state efforts to improve the quality of child care in general and the enforcement of state standards in particular. We conducted a telephone survey of licensing directors in 50

[1]Appendix II provides definitions for child care settings used in this report.

[2]Willer, B.; S. Hofferth; E. Kisker; P. Hawkins: E. Farquhar; and F. Glantz, The Demand and Supply of Child Care in 1990: Joint Findings from The National Child Care Survey 1990 and a Profile of Child Care Settings, National Association for the Education of Young Children, U.S. Department of Education, U.S. Department of Health and Human Services (Washington, D.C., 1991), p. 16.

states and the District of Columbia[3] and visited four states; interviewed child care experts at national, state, and local levels; and reviewed literature on child care issues related to quality, standards, and licensing. At the time of our review, the Department of Health and Human Services (HHS) had approved applications for CCDBG funds from 26 states and had begun to disperse the funds to them. The remaining states were awaiting approval of their applications. Appendix I describes our scope and methodology in detail. Appendix II presents additional information on state activities from our survey.

Background

CCDBG provides funds to the states based on a formula that reflects the number of children younger than age 5, the number of children receiving free or reduced-price lunches in the state, and the state per capita income. To apply for funds, states must submit a plan to HHS that includes information on how CCDBG funds will be used for purchasing child care services and improving the availability and quality of child care.

CCDBG gives states flexibility about how much they can spend on activities intended to enhance quality (for example, licensing) within broad statutory limits. However, the intent of the statute was that less money be spent on quality activities than for purchasing care. HHS's regulations further restrict state spending on quality. The states are permitted to spend money on enhancing quality within five categories of activities: monitoring efforts, training and technical assistance to providers, resource and referral programs,[4] financial assistance to help providers meet standards, and increasing salaries and benefits to child care providers.

Under the act, states retain primary responsibility for regulation and oversight of child care providers.[5] However, CCDBG mandates that states establish child care standards in the areas of physical premise safety, control of infectious diseases, and provider health and safety training. In addition, states must assure the federal government that the providers paid with CCDBG funds meet all applicable state and local child care

[3]For the purposes of this report, the District of Columbia is referred to as a state.

[4]Resource and referral agencies (R&Rs) match parents looking for child care with child care providers. R&Rs are usually funded by state or local child care agencies, private employers, or both. In addition to helping parents find child care, states contract with R&Rs to conduct other services, such as provider orientation and training classes.

[5]States do not require that all child care providers meet state standards, and many states exempt or do not regulate a significant number of providers. For example, The Demand and Supply of Child Care in 1990 estimates that between 82-90 percent of family day care providers are unregulated. Appendix II (table II.1) provides information from our survey on the types of providers who are licensed, registered, exempted, or unregulated.

standards. For those providers who are regulated, all states set minimum health standards (for example, immunization requirements) and minimum safety standards (for example, building and fire code requirements)—basic components of quality care—and many regulate other programmatic aspects of care, such as the ratio of staff to children, qualifications of the provider, and organization of the space.[6] Specific requirements, however, vary from state to state.

Results in Brief

Many states face difficulties protecting children from care that does not meet minimum safety and health standards. In particular, staffing and budget cuts in several states have reduced on-site monitoring, a key oversight activity that is necessary for the enforcement of standards. Many states are trying methods less costly than monitoring to ensure compliance with standards and influence the quality of care; however, little is known about their effectiveness.

Since CCDBG is in the early stages of implementation, it is too soon to evaluate its effect on child care quality. However, many state officials are concerned that CCDBG funds for quality improvement, especially as limited by HHS's regulations, will not be enough to sustain their efforts directed at quality. Moreover, they anticipate an influx of new CCDBG providers that could increase caseloads and further erode their capacity to regulate providers and undertake additional quality improvement activities.

Under these circumstances, the meaningfulness of state assurances to HHS about provider compliance with state standards, as required by CCDBG, may be diminished. However, most state officials indicate they could improve their own enforcement efforts with technical assistance and more information about promising approaches in other states. HHS can assist the states by helping them evaluate the effectiveness of state efforts directed at improving quality through enforcement of child care standards and other activities and then disseminating information states can use to improve care. In addition, HHS should assess the success of states in expanding service quantity as well as improving quality, given the states' current resources. If necessary, HHS should modify its regulations to better ensure that states do not expand quantity at the expense of quality.

[6]For more information on variation in state child care standards see, The National State of Child Care Regulation 1989, Gwen Morgan, Work/Families Direction, Boston (forthcoming).

States Rank On-Site Monitoring as the Most Effective of All Regulatory Activities

In all states, the core activities for regulating providers include screening, on-site monitoring, and imposing sanctions. Such activities constitute a state's licensing or registration process.[7] States screen prospective providers to determine suitability, conduct on-site monitoring to determine if providers are complying with the standards, and impose sanctions if providers are not complying. For all types of care, licensing directors ranked on-site monitoring as the most effective regulatory activity for assuring provider compliance with state child care standards. (See figure II.4).

Screening

In our survey, eight states ranked screening activities for centers and family day care homes as their most effective regulatory activity to ensure compliance with standards, and seven ranked it as most effective for group homes. States conduct screening before licensure or registration as a way of weeding out individuals who are unqualified (for example, those too young) or unsuitable (for example, those with a criminal conviction). Some states also educate applicants about state child care requirements during the screening process. Several child care experts consider screening important because it can detect those people attracted to child care who believe it may be an easy business to start but who may be unsuitable or poorly qualified to care for children. They believe that preventing such providers from entering the regulated market in the first place is more cost efficient than facing enforcement problems later.

Appendix II (see table II.2) shows the variation among states in their screening activities. For example, while all 51 states require prior approval of health, safety, and zoning inspections for centers, 32 states conduct child-abuse-registry checks for center personnel.

On-Site Monitoring

Through on-site monitoring, state licensing officials periodically visit providers in order to oversee daily operations and determine the provider's compliance with state standards. Over two-thirds of state licensing directors in our survey ranked on-site monitoring of centers and group homes as their most effective activity for ensuring compliance, and over half ranked it as the most effective for family day care homes (see

[7]States, local governments, or both, usually license providers, such as centers, caring for larger numbers of children and register providers, such as family day care homes, caring for fewer children. Licensing is typically a stricter form of regulation in which states require compliance with more stringent standards and usually monitor providers more frequently. Registration, in contrast, may require only that providers give a name and address to the state and self-certify that they are in compliance with applicable standards, although some registration systems are as complex as licensing.

app. II, figure II.4). These state licensing directors believe that an on-site presence helps deter noncompliance and can provide an opportunity to educate or consult with providers to help them find reasonable ways to comply. In this regard, such monitoring provides both an oversight and prevention tool to states for ensuring that providers maintain a basic level of quality. The frequency of on-site monitoring varies by state and type of provider, as shown in appendix II (see figure II.1 and table II.3).

Appendix II (see figure II.2 and table II.3) also shows that states conduct a combination of announced and unannounced monitoring visits to providers, although most states conduct unannounced visits to investigate complaints. While unannounced visits can provide deterrence to noncompliance, an announced visit may be necessary, for example, when the provider needs to prepare paperwork for the visit.

Sanctions

Our survey shows that 14 licensing directors ranked imposing sanctions as the second most effective tool for centers in ensuring compliance (app. II, figure II.4). Sanctions are penalties a state licensing unit may impose when a provider is out of compliance with state standards and, as such, are linked to a state's monitoring activities, the primary tool through which states are able to observe the compliance level of its providers. Sanctions range from requiring corrective action plans, which help bring the provider into compliance, to closing a facility (app. II, table II.2).

Sanctions in some states are difficult to impose because of a lack of staff or direct authority by the state licensing unit. For example, in one state every sanction (except for corrective action plans) required the licensing unit to seek prior approval of an external committee. Another state director told us that staff shortages caused the licensing unit to take 6 months to sanction a provider. As shown in appendix II (see table II.2), almost all states can deny relicensing and establish corrective action plans for less serious violations, and several can levy fines.

States Are Less Able to Conduct On-Site Monitoring

Many States Conduct Monitoring Less Frequently

Our survey results indicate that efforts to screen providers and impose sanctions have been maintained in most states but the capacity of several states to conduct on-site monitoring has eroded recently. States are conducting on-site visits less frequently than in the past or less frequently than their state policy requires. Specifically, 18 states reported a decrease in the frequency of visits since 1989; they are now visiting centers, for example, between once every 3 years to 4 times a year, averaging 1.7 visits a year. Moreover, 13 states were unable to meet their own monitoring requirements for centers—most required visits, on average, twice a year but were visiting centers about once a year.

We compared states' reported practices with monitoring standards for child care centers established by the National Association for the Education of Young Children (NAEYC).[8] Our survey found that 20 states did not meet NAEYC's minimum standard that states conduct at least one unannounced visit to each center every year. Moreover, NAEYC recommends a higher standard of at least two visits per year, with one visit being unannounced. In our survey, 39 states did not meet this standard.

Many states are trying to stretch scarce monitoring resources in several ways:

- prioritizing inspections so that resources are concentrated on providers who have a poor compliance history;
- streamlining visits by focusing on a limited number of standards (for example, group size ratios) which, when not met, are indicators of more widespread noncompliance;[9]
- providing specialized training for inspectors in areas such as investigation of sexual or physical abuse complaints; and

[8]NAEYC is the nation's largest association of early childhood professionals. Its purpose is to improve professional practice in early childhood care and education and increase public understanding of high-quality early childhood programs. It also accredits, through a voluntary system, early childhood education centers and schools.

[9]Fiene, Richard, "The Instrument Based Program Monitoring Information System and the Indicator Checklist for Child Care," Child Care Quarterly, 14(3), Fall 1985, pp. 204-206.

- automating administrative data collection tasks to process paperwork more quickly.

States report plans to use CCDBG quality improvement funds to conduct such activities (see figure II.3).

Monitoring Cutbacks Linked to Fiscal Constraints and Increased Numbers of Providers

In most cases, budget cutbacks and the resulting lack of staff in addition to increased numbers of providers were the major reasons states cited for difficulties in conducting on-site monitoring. States' concerns are underscored by national data on the fiscal crises facing many states.[10] One study, for example, reports that 32 states had to cut funding and staff for programs and local governments. Examples of budget-reduction strategies of states include hiring freezes (25 states); across-the-board cuts in all state agencies (14 states); layoffs of state workers (12 states); and, furloughs of state employees (7 states).[11]

In addition, many state licensing directors told us that they experienced moderate to significant increases in inspector caseloads over the last 3 years, mostly due to increased numbers of providers. Specifically, 39 reported higher caseloads for centers, 26 for group homes, and 34 for family day care homes. Furthermore, 31 states are predicting moderate to significant increases in caseloads for the next 2 years, partly attributable to CCDBG funding for expanded services.

States Are Trying Other Methods to Ensure Safety and Health in Child Care Settings

To supplement screening, monitoring, and sanctioning efforts, states are using other nonregulatory methods to bring more providers into compliance with state standards and raise quality across all types of care.[12] Specifically, many states educate consumers, train providers, maintain and publicize complaint hotlines, and require liability insurance. Many state directors think that their programs to educate consumers and train providers are particularly useful and rate them moderately or significantly effective in helping to ensure compliance and promote quality among regulated and unregulated providers.

[10]U.S. General Accounting Office, Intergovernmental Relations: Changing Patterns in State-Local Finances (GAO/HRD-92-87FS, Mar. 31, 1992), p. 1.

[11]National Association of State Budget Officers, Fiscal Survey of States: October 1991, pp. ix and 34.

[12]Some of these methods are required by CCDBG.

Educating Parents

Several licensing officials and other experts believe that educating parents will result in better care because parents will demand quality and providers will respond. As shown in appendix II (see table II.2), 26 states educate parents about indicators of quality care. Licensing units educate parents by distributing publications about child care and provider policies to them and by requiring providers to give copies of state child care regulations to parents.

Training Providers

Research shows that provider training is associated with more frequent, warm, and developmentally appropriate interactions between the child and the provider.[13] Twenty-six states support or sponsor broader-based efforts to train providers in early childhood education or development (see app. II, table II.2). Furthermore, training providers about reasons for standards helps motivate them to comply. We found that 37 states teach providers about state child care standards and help them understand how complying with these standards can reduce risks and injuries to children.

Establishing Complaint Systems

All states have complaint systems that allow parents and others to alert licensing officials to problems that might otherwise go undetected. Some view the complaint process as extending a state's monitoring capacity because parents can observe provider operations every day. In our survey, many states require providers to tell parents how to make complaints; however, a majority of the states do not publicize a complaint hotline. Specifically, 42 do not for centers, 29 do not for group homes, and 44 states do not for family day care homes.

Requiring Liability Insurance

Twenty states require child care centers to carry liability insurance and five require such insurance for group and family day care homes. To reduce their risk of adverse claims, insurers typically require providers to meet safety and health standards before they will issue them a policy. One expert told us that premiums may be lower in states that require more on-site monitoring and that providers with good records can obtain lower premiums. On the other hand, liability insurance may be expensive and difficult to obtain in some states, raising barriers for providers entering the child care market.

[13]National Research Council, Who Cares for America's Children?, National Academy Press, Washington, D.C., 1990, pp. 102-103.

States Want More Information About the Effectiveness of Quality Activities

Resource constraints have caused states to look for ways to conduct licensing and other quality improvement activities more efficiently. However, little is known about the effectiveness of different activities, used alone or in various combinations, and about state strategies that work well.

Some states are placing more emphasis on preventive activities, such as expanded screening in the regulatory area, and parental education and provider training in the nonregulatory area. The effectiveness of these methods is not yet known, although they can be less costly than monitoring. While there is substantial research, for example, showing that providers with child-development training interact with children in more appropriate ways,[14] much less information exists about the effect of other preventive activities on provider compliance and quality. Therefore, states do not know how well their new focus on these activities could compensate for reduced levels of monitoring.

Many states share common problems and needs, especially in trying to identify the best practices for ensuring the quality of care through enforcing standards. While the HHS Inspector General has conducted some studies on child care and disseminated their results to states,[15] our survey indicates that states want HHS to provide more opportunities for states to learn from one another. For example, 37 states said that they would find it useful for HHS to disseminate information about other state licensing activities, possibly through continued sponsorship of conferences[16] or a clearinghouse function. Furthermore, 35 states want HHS to provide technical assistance on matters, such as development of automated child care information systems, and 34 want HHS to help with data collection activities, such as a way to establish a national criminal history registry.

[14]Who Cares for America's Children?, pp. 89-90.

[15]Office of the Inspector General, Office of Evaluations and Inspections, Enforcing Child Care Regulations; and Effective Practices in Enforcing Child Care Regulations, February 1990, p. 19.

[16]In August 1991, California's Department of Social Services sponsored a national licensing conference so that states could share information on ways to "efficiently and effectively operate licensing programs in a time of diminishing resources." The conference was funded, in part, through the Licensing and Monitoring Improvement Grant program of the Family Support Act of 1988, administered by HHS.

States Are Unsure of Potential for CCDBG Funds to Improve Quality

Many state licensing directors either did not anticipate any impact or were unsure about the extent to which CCDBG funds would sustain or expand their licensing and other quality improvement activities. Many were uncertain because their states were in the early stages of implementing CCDBG. They were also concerned that HHS regulations would unduly restrict the amount of money states can use for quality activities.

The statute requires that at least 5 percent of total funds be spent on improving quality. At the time of our review, the interim regulations limited the amount states could spend on improving the quality of child care services to 17.5 percent of total funds for the first 2 years, dropping to 13.75 percent for the remaining years of implementation. States were predicting that administrative costs—specifically for the certificate payment systems required by CCDBG—would be significant, and while CCDBG allows these costs to be paid for with CCDBG funds, the regulation restricted states to drawing from this same amount of money. Consequently, states were concerned that too few dollars would be available to maintain and improve quality of care.

On August 4, 1992, HHS issued final regulations. Responding to comments, HHS now allows states to spend 17.5 percent of total CCDBG funds beyond the first 2 years of implementation for authorized activities other than purchase of care, including improving quality, if a state documents that the administrative cost for establishing its certificate and consumer education programs represent at least 7.5 percent of its total CCDBG funds. Many states are concerned that administrative costs for certificates in particular could well exceed 7.5 percent. To the extent the states are correct, funds available for quality will be closer to the minimum mandated by the statute.

Conclusions

In addition to subsidizing child care for low-income families, CCDBG directs funds for quality-of-care improvements and requires states to assure the federal government that providers are meeting minimum health and safety standards. However, tight fiscal conditions in many states have weakened their capacity to enforce standards and conduct other activities aimed at improving the quality of care. States have further difficulty because they do not have enough information about the effectiveness of alternative ways to improve quality, which are critical for allocating their limited resources.

In the wake of budget cuts, several states have had to reduce on-site monitoring of providers—a key oversight activity. As a result, many states are trying to conduct monitoring more efficiently and focus on preventive strategies, such as expanded screening, provider training, and parental education, as ways of improving quality with fewer state resources. The risk of doing this is that little is known about the effects on provider compliance of the various activities states are pursuing and, in particular, to what degree they could compensate for reduced on-site monitoring levels. To this end, HHS could help states develop and share data on the effectiveness of different quality improvement activities.

While CCDBG funds state activities to improve quality, most of the money under the statute and regulations pay for child care services. State officials were not sure that CCDBG funds for quality improvements would have much effect, especially if state budget constraints continue and heavy caseloads worsen as new providers paid with CCDBG funds enter the child care market. Although the final HHS regulations may alleviate state concerns to some degree, we believe that the effect of CCDBG funds on quality activities remains unclear. This is due to the uncertainty about the future fiscal health of states and the extent to which new providers will continue to enter the child care market. Therefore, assessing whether both of CCDBG's goals are achieved or whether the quantity of child care services under CCDBG will exceed the capacity of the states to ensure an acceptable level of care will be important.

Recommendations

We recommend that the Secretary of HHS:

- assess state efforts to enforce their child care standards and improve quality of care while expanding child care services and, if necessary, modify HHS regulations that restrict state spending on quality.
- lead and support efforts to determine the effectiveness of various ways to ensure compliance and promote quality among different types of child care settings.
- collect and disseminate information to states through newsletters, hotlines, or national conferences about activities that are working well in other states.

Agency Comments

HHS provided us comments on a draft of our report in which they generally concurred with our conclusions and recommendations (see app. III). However, HHS noted that it believes, at this time, CCDBG regulations do not

unduly restrict money for quality. In its response to our recommendations, HHS mentioned its plans to gather information from states on "best practices" about ensuring provider compliance and promoting quality and to hold seminars and conferences to disseminate this information.

HHS also had a concern about potential misunderstanding surrounding limits on administrative costs. HHS argues that administrative costs are not limited if these costs are associated with quality activities for which CCDBG requires states to reserve money, such as establishing before- and after-school care or developing resource and referral agencies. We agree. However, while administrative costs for these types of activities are not capped, those associated with the CCDBG-required certificate payment systems are. And, as the report discusses, the costs for establishing and supporting certificate systems are of great concern to the states.

Technical comments were also provided, and we made changes based on these comments, where appropriate, in finalizing the report.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 15 days from the date of this letter. At that time, we will send copies to the Secretary of Health and Human Services, the directors of state agencies for child care licensing, and child care experts who participated in our review. We will also make copies available to other interested parties on request.

Please call me on (202) 512-7215 if you or your staff have any questions about this report. Other major contributors are included in appendix III.

Joseph F. Delfico

Joseph F. Delfico
Director, Income Security Issues

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Abbreviations

CCDBG	Child Care and Development Block Grant
FDC	family day care
GH	group home
HHS	Department of Health and Human Services
NAEYC	National Association for the Education of Young Children

Scope and Methodology

In performing this review, we (1) conducted a telephone survey of 51 state licensing directors (directors in 50 states and the District of Columbia); (2) visited child care licensing units in four states; (3) interviewed officials from federal, state, and local child care agencies, and other child care experts; and (4) reviewed the literature on child care issues related to quality of care, licensing, and standards. At the time that we called state licensing directors, HHS had approved 26 state applications and had begun to distribute CCDBG funds to those states. The remaining states were awaiting approval of their applications.

Through our telephone survey we obtained information on state efforts for ensuring safe and healthy child care settings. Specifically, we gathered information on (1) state activities to ensure child care provider compliance with state standards and officials' opinions as to the activities' effectiveness, (2) trends in these state activities, and (3) opinions as to the future impact of CCDBG funds on state efforts to enforce standards and improve quality in other ways. Our response rate was 100 percent.

In developing our survey instrument, we conducted a group interview comprised of officials from a variety of child care backgrounds and interests, including representatives from state licensing agencies, national child care associations, and universities. Our draft instrument was reviewed by experts from academia and state and federal governments.

To augment the information we received through our telephone survey, we conducted in-depth site visits in four states: California, Michigan, Pennsylvania, and Texas. These states were selected based on geographic diversity, their large numbers of child care providers, and differences in their state requirements and regulatory efforts. During our visits, we interviewed and collected data from state licensing directors, licensing supervisors and inspectors, resource and referral agencies, and child care provider associations.

In addition, we spoke with officials from the Administration for Children and Families at HHS, HHS's Office of the Inspector General, the Bureau of the Census, and the Bureau of Labor Statistics, and staff from the National Association for Regulatory Administration, the National Association for the Education of Young Children, the Children's Defense Fund, and the Child Welfare League.

We performed our review between March 1991 and May 1992 in accordance with generally accepted government auditing standards.

State Data on Licensing and Enforcement Activities

This appendix provides data collected in our survey on the variation across states in child care licensing and enforcement activities. The information complements the existing literature on variations in state standards by focusing on enforcement of these standards and other measures states pursue to improve quality of care. Our intent in displaying these data is not to show or suggest deficiencies in state activities, but to capture, in a visual way, this variation.

These data give baseline information on state activities just before and during states' early implementation of CCDBG. However, on-going regulatory reviews conducted by states and tenuous budget situations cause changes in state policies and their implementation. Consequently, these data should be considered a "snapshot" of state enforcement activities at the time of our review, which was between March 1991 and May 1992.

The appendix presents information on screening, on-site monitoring, complaint investigations, sanctioning, other quality improvement activities, and reported state plans for using CCDBG funds for these activities.

Definitions of Child Care Settings

The following definitions for child care settings were used for the purposes of this survey.

Center care: Care provided in nonresidential facilities, usually for 13 or more children.

Group home care: Care provided by two or more caregivers, typically for 7 to 12 children.

Family day care: Care provided in a private residence other than the child's home, usually for 6 or fewer children.

Relative care: Care provided by a related person other than the parent.

Table II.1: Number of States that License, Register, and Exempt Types of Child Care Providers

Types of Providers	Licensed	Registered	Exempt or unregulated
Centers			
Commercial facility-based	51	•	•
Religious-based	49	•	12
School-based (before and after school)	46	3	31
School-based (pre-school)	41	2	32
Work-site based	50	•	8
Group homes[a]	34	4	•
Family day care			
Nonrelative	27	28	28
Relative	4	10	49

Note: State responses may exceed 51 for some provider types because states regulate and exempt providers within the same provider category. For example, a state may require that a family day care provider who cares for six or more children be licensed, but exempt from regulation a family day care provider caring for fewer children.

[a]Thirteen states do not have group home definitions.

Table II.2: State Activities to Help Ensure Caregiver Compliance

	Number of states reporting		
Activity	Centers	Group homes[a]	Family day care[b]
Applicant screening			
Completed application	51	38	50
Health, safety, and zoning inspections	51	33	27
Prior on-site inspection by licensing unit	50	34	34
Proof of primary caregiver's medical exam	38	30	33
Proof of primary caregiver's credentials	45	28	20
Reference checks	35	26	37
Interview with primary caregiver	35	25	31
Fingerprint checks and/or criminal record checks	34	26	29
Child-abuse-registry check	32	27	33
Attendance in orientation session	15	12	22
On-site inspections			
Initial license	49	34	36
Renewal license	48	33	31
Compliance	41	31	34
Complaints	51	38	48

(continued)

Activity	Number of states reporting		
	Centers	Group homes[a]	Family day care[b]
Sanctions			
Establish a corrective action plan	51	38	48
Deny relicensing[c]	50	37	48
Revoke license for a cause[d]	50	37	50
Close a facility immediately	46	35	43
Suspend license [e]	39	29	35
Condition a license[f]	30	22	24
Place facility on probation[g]	29	22	23
Levy a monetary fine	19	14	16
Post a conspicuous public notice of violation	11	8	8
Training on			
Licensing standards/procedures	37	25	30
Child development curriculum	26	15	21
Health and safety	32	24	29
Consumer/parent education	26	18	25

Note: Maximum number of responses: centers, 51; group homes, 38; and family day care, 50.

[a]Thirteen states do not have group home definitions.

[b]Mississippi does not regulate family day care homes.

[c]State denies renewal of a provider's license.

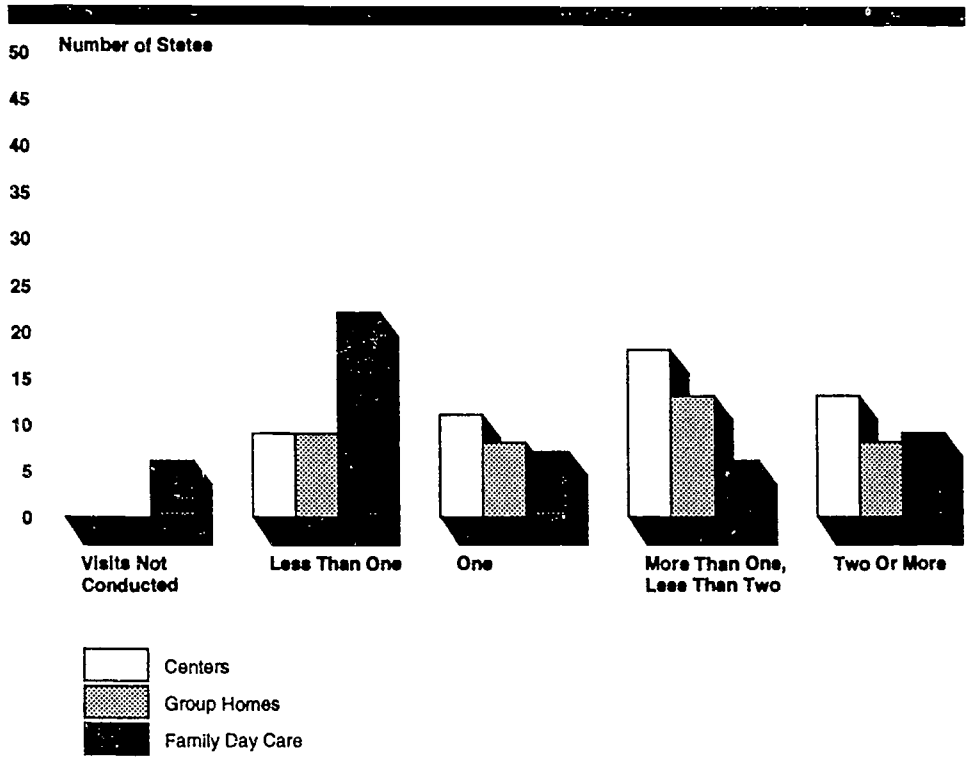
[d]Prohibits a provider from operating a facility, although a provider may reapply for a license or registration after a period of time.

[e]Prohibits a provider from operating a facility for the period of time that will allow for the correction of the noncompliance.

[f]Restricts the provider from full operational use of the existing license.

[g]Requires a provider to bring a facility into compliance within a certain period of time after the noncompliance is determined.

Figure II.1: Number of Yearly Visits Conducted by States



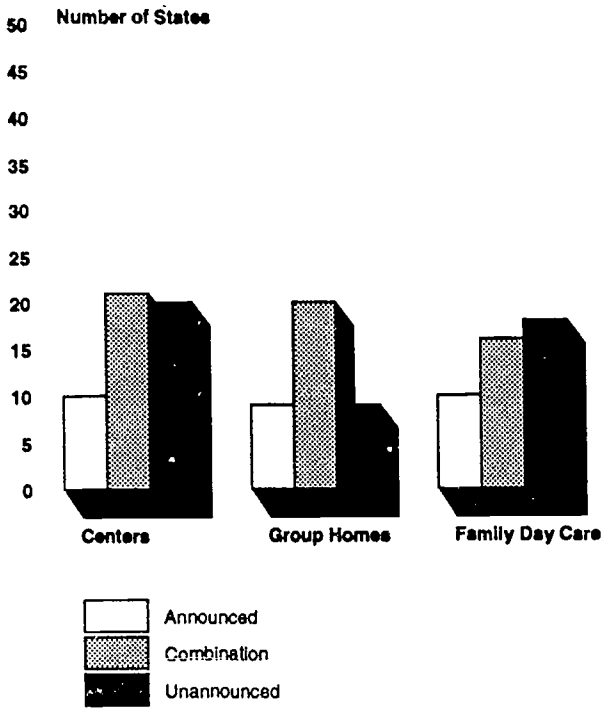
Note: Groupings represent the average number of yearly visits conducted by a state. For example, Mississippi conducts 3 visits every 2 years for centers, averaging 1.5 visits a year, and is included in the "More Than One" grouping.

Totals include both renewal and compliance visits.

Maximum response rates: Centers, 51; Group homes, 38; and Family day care, 50.

Thirteen states do not have group homes, and Mississippi does not regulate family day care.

Figure II.2: Number of States Conducting Announced or Unannounced Visits



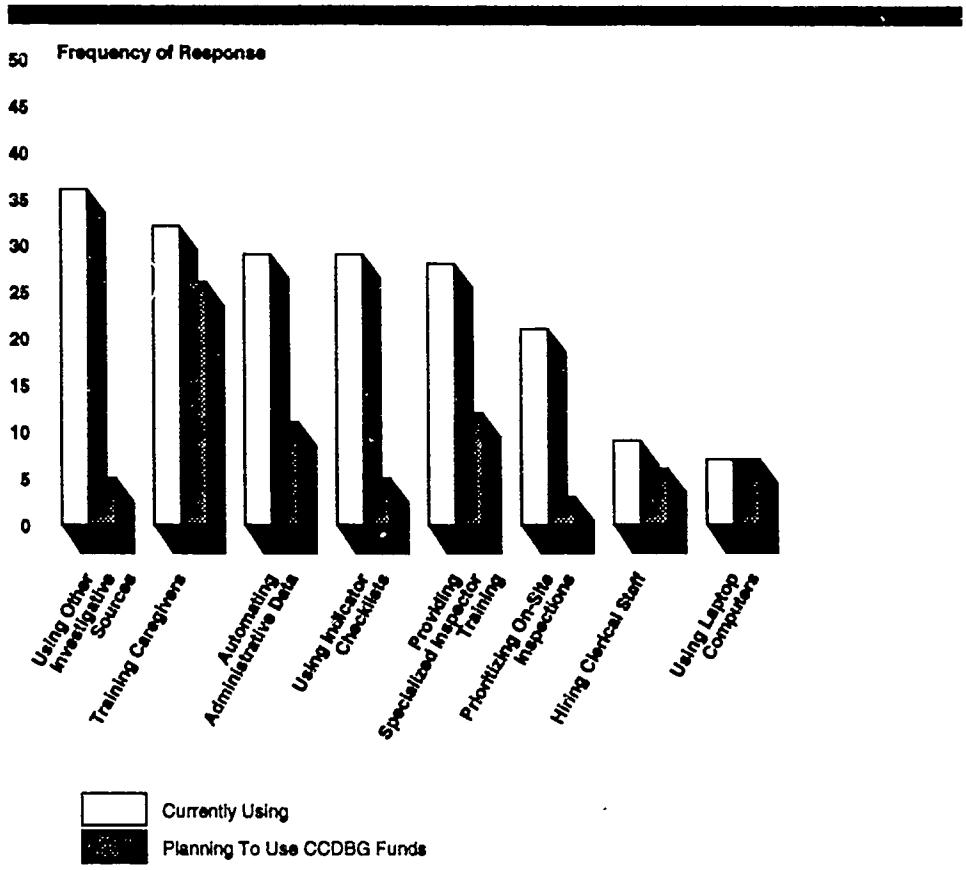
Note: Maximum response rates: Centers, 51; Group homes, 38; and Family day care, 50.

Numbers include both renewal and compliance visits.

Thirteen states do not have group homes.

Six states do not conduct on-site visits to family day care homes, and Mississippi does not regulate family day care.

Figure II.3: Ways States Use Monitoring Resources More Efficiently



Maximum response rate is 51.

Table II.3: Frequency and Type of Visits Conducted by State

	Frequency of visits		
State	Centers	Group home (GH)	Family day care
Alabama	1 every yr.	1 every yr.	1 every yr.
Alaska	1 every yr.	No GH category	1 every yr.
Arizona	4 every 3 yrs.	7 every 3 yrs.	5 every yr.
Arkansas	5 every 2 yrs.	5 every 2 yrs.	1 every 2 yrs.
California	2 every yr.	1 every 3 yrs.[a]	1 every 3 yrs.
Colorado	1 every 2 to 6 yrs.	1 every 2 to 3 yrs.	3 every 2 yrs.
Connecticut	1 every 2 yrs.	1 every 2 yrs.	33 1/3% sample
Delaware	1 every yr.	1 every yr.	3% sample
District of Columbia	1 every yr. & 10% sample	No GH category	1 every yr. & 5% sample
Florida	4 every yr.	No GH category	2 every yr.
Georgia	1 every yr. & as needed	1 every yr. & as needed	None
Hawaii	1 every yr. & as needed	1 every yr. & as needed	1 every yr. & as needed
Idaho	1 every 2 yrs.	1 every 2 yrs.	1 every 2 yrs.
Illinois	1 every yr.	1 every yr.	1 every yr.
Indiana	1 every yr. & as needed	No GH Category	1 every yr. & as needed
Iowa	1 every yr.	5-20% sample	5-20% sample
Kansas	1 every yr.	1 every yr.	None[b]
Kentucky	1 every yr.	No GH category	1 every yr.
Louisiana	5 every yr.	No GH category	None
Maine	4 every yr.	No GH category	2 every yr.
Maryland	1 every yr.	1 every yr.	1 every 2 yrs.
Massachusetts	1 every 2 yrs. & 30% sample	No GH category	1 every 3 yrs. & 30% sample
Michigan	1 every 2 yrs. & 10% sample	1 every 2 yrs. & 10% sample	1% sample
Minnesota	1 every yr. & 20% sample	1 every yr. & 10% sample	1 every yr. & 10% sample
Mississippi	3 every 2 yrs.	3 every 2 yrs.	None
Missouri	5 every 2 yrs.	5 every 2 yrs.	5 every 2 yrs.
Montana	1 every yr.	20% sample	20% sample
Nebraska	3 every 2 yrs.	3 every 2 yrs.	24% sample
Nevada	4 every yr.	4 every yr.	4 every yr.
New Hampshire	1 every 3 yrs.	1 every 3 yrs.	1 every 3 yrs.

Type of visit conducted					
Renewal			Compliance		
Centers	Group home	Family day care	Centers	Group home	Family day care
UA	UA	UA	UA	UA	UA
A	NA	A	A	NA	A
UA	UA	A	UA	UA	B
A	A	A	UA	UA	UA
UA	UA	UA	UA	NC	NC
UA	A	A	NC	NC	UA
UA	UA	NC	NC	NC	UA
A	A	NC	NC	NC	UA
UA	NA	UA	UA	NA	UA
UA	NA	UA	UA	NA	UA
UA	UA	NC	UA	UA	NC
A	A	A	B	B	B
A	A	A	NC	NC	NC
A	A	A	UA	UA	UA
UA	NA	UA	UA	NA	UA
A	NC	NC	NC	B	B
UA	UA	NC	NC	NC	NC
UA	NA	UA	NC	NA	NC
UA	NA	NC	UA	NA	NC
UA	NA	UA	UA	NA	UA
A	A	A	NC	NC	NC
A	NA	UA	UA	NA	UA
A	A	NC	A	A	A
UA	A	A	UA	UA	UA
UA	UA	NC	A	A	NC
B	B	B	B	B	B
A	NC	NC	NC	A	A
A	A	NC	UA	UA	UA
UA	UA	UA	UA	UA	UA
A	A	A	NC	NC	NC

(continued)

State	Frequency of visits		
	Centers	Group home (GH)	Family day care
New Jersey	1 every 3 yrs. & as needed	No GH category	1 every 3 yrs. & 20% sample
New Mexico	3/yr.	3/yr.	3/yr.
New York	3 every 2 yrs.	3 every 2 yrs.	20% sample & as needed
North Carolina	1 every yr. & 25% sample	1 every yr. & 50% sample	1 every 2 yrs. & 25% sample
North Dakota	1 every 2 yrs. & as needed	1 every 2 yrs. & as needed	1 every 2 yrs. & as needed
Ohio	1 every yr. & 60% sample	1 every yr. & 60% sample	1 every yr.[c]
Oklahoma	4 every yr.	No GH Category	4 every yr.
Oregon	1 every yr. & 70-80% sample	1 every yr. & 70-80% sample	None
Pennsylvania	1 every yr.	1 every yr.	5% sample
Rhode Island	2 every yr.	2 every yr.	1 every 2 yrs.
South Carolina	5 every 2 yrs.	5 every 2 yrs.	None[d]
South Dakota	1 every yr. & as needed	1 every yr. & as needed	1 every 2 yrs. & as needed
Tennessee	2 every yr.	2 every yr.	2 every yr.
Texas[e]	1 to 3 every yr.	1 to 3 every yr.	20% sample
Utah	4 every 3 yrs.	1 every yr.	1 every yr.
Vermont	3 every 2 yrs.	No GH Category	20% sample
Virginia	2 every yr.	No GH Category	2 every yr.
Washington	4 every 3 yrs.	4 every 3 yrs.	1 every 3 yrs.
West Virginia	1 every 2 yrs.	No GH Category	1 every yr.
Wisconsin	3 every 2 yrs.	3 every 2 yrs.	None
Wyoming	1 every yr.	1 every yr.	1 every yr.

Type of visit conducted					
Renewal			Compliance		
Centers	Group home	Family day care	Centers	Group home	Family day care
UA	NA	B	UA	NA	UA
UA	UA	UA	UA	UA	UA
A	A	UA	UA	UA	UA
A	A	A	UA	UA	UA
A	A	A	UA	UA	UA
A	A	A	B	B	B
UA	NA	UA	UA	NA	UA
A	A	NC	UA	UA	NC
A	A	NC	UA	UA	B
UA	A	A	UA	UA	NC
A	A	NC	A	A	NC
A	A	A	UA	UA	UA
A	A	A	UA	UA	UA
NC	NC	NC	B	B	UA
A	A	A	UA	NC	NC
A	NA	NC	UA	NA	UA
A	NA	A	B	NA	B
A	A	A	B	B	NC
A	NA	A	NC	NA	NC
A	A	NC	UA	UA	NC
UA	UA	UA	UA	UA	UA

Legend:

A=Announced.
B=Both announced and unannounced.
NA=Not applicable.
NC=None conducted.
UA=Unannounced.

Note: Samples are randomly selected on an annual basis. This table reflects information on routine renewal and compliance visits. Some states may, however, conduct other visits as deemed necessary (for example, investigating complaints), which are not reflected here.

[a]California differentiates between small and large family day care. Its large family day care definition corresponds with GAO's group home definition.

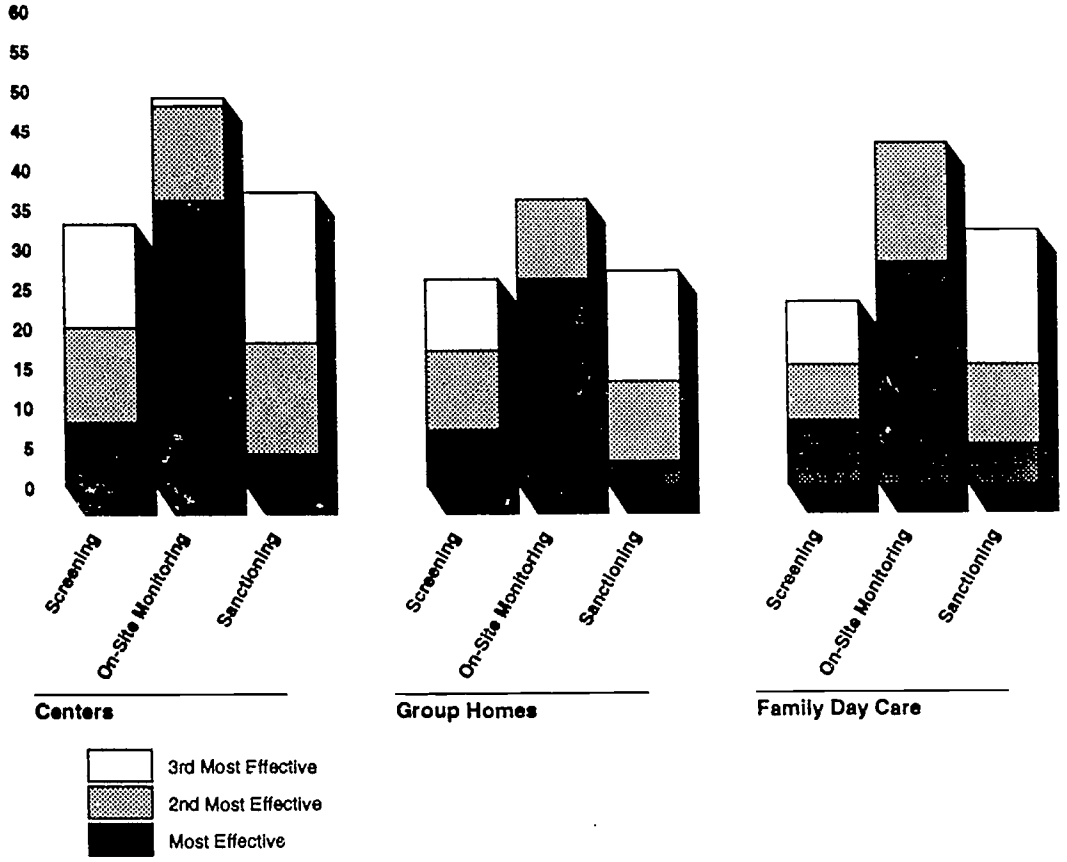
[b]Denotes registered family day care; licensed family day care is monitored similarly to group homes.

[c]Includes renewal visits only. Compliance visits are conducted by county officials and total visits could exceed one a year.

[d]Denotes registered family day care only. Licensed family day care is monitored with the same frequency as centers.

[e]Facilities are issued nonexpiring licenses. Renewal visits are conducted only when facilities change ownership or make a significant policy change.

Figure II.4: Screening, On-Site Monitoring, and Sanctioning; How Licensing Unit Directors Ranked Their Effectiveness



Note: Maximum response rates: Centers, 51; Group homes, 38; and Family day care, 50.

Thirteen states do not have group homes

Six states do not conduct on-site visits to family day care homes, and Mississippi does not regulate family day care.

Comments From the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

OCT 13 1992

Mr. Joseph F. Delfico
Director, Income Security
Issues
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Delfico:

Enclosed are the Department's comments on your draft report, "Child Care: States Face Difficulties Enforcing Standards and Promoting Quality." The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely yours,

Bryan B. Mitchell
Principal Deputy Inspector General

Enclosure

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COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ON THE U.S. GENERAL ACCOUNTING OFFICE'S DRAFT REPORT, "CHILD CARE: STATES FACE DIFFICULTIES ENFORCING STANDARDS AND PROMOTING QUALITY" REPORT NO. HRD-92-131

General Comments

In general, there seems to be some misunderstanding of the limitation on administrative costs under the program. Under the final regulation, grantees may expend up to 15 percent of the 75 percent portion on administration, quality and availability improvements. At least 20 and up to 25 percent of the 25 percent portion of the program is available for quality improvements. There is no limit on administrative costs under this latter portion of the Child Care and Development Block Grant (CCDBG). However, the final regulation at 45 CFR 98.50(d)(3) restricts the circumstances under which up to 15 percent of the 75 percent portion can be used for other than direct services (a restriction not described in GAO's report). As a consequence, the maximum that may be expended for quality improvements is 13.75 percent (10 percent of the 75 percent portion and 25 percent of the 25 percent portion) of the CCDBG.

GAO Recommendation

We recommend that HHS assess state efforts to ensure that quality of care is maintained while expanding services and, if necessary, modify its regulations restricting state spending on quality improvements.

Department Comment

We concur regarding assessing State efforts to maintain quality child care. In fact, the CCDBG statute and regulations provide that grantees report annually to the Secretary of HHS regarding results of reviews of licensing and regulatory requirements for health and safety, any reductions in State child care standards, standards in the area served by the grantee and any grantee actions to improve quality.

At this time, we do not believe that the final regulation excessively restricts grantee spending on quality improvements.

GAO Recommendation

We recommend that HHS lead and support efforts to determine the effectiveness of various ways to ensure compliance and promote quality among different types of child care settings.

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Department Comment

We concur. Beginning with Fiscal Year 1993, we propose to conduct program monitoring reviews in approximately half of the States. The results of these reviews will enable us to identify best practices and ensure that grantees are in compliance with the statute.

GAO Recommendation

We recommend that HHS collect and disseminate information to states through newsletters, hotlines, or national conferences about activities that are working well in other states.

Department Comment

We concur. Through a contract, we propose to provide training and technical assistance to grantees through such activities as conferences, seminars, and "best practice" papers.

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